

CITY OF SOMERVILLE  
BOARD OF HEALTH  
CITY HALL ANNEX  
50 EVERGREEN AVENUE  
SOMERVILLE, MA 02145  
(617)625-6600 EXT. 4300

MASSAGE PRACTITIONER LICENSE APPLICATION

License filing fee of \$150 submitted: Yes\_\_\_\_\_No\_\_\_\_\_

Applicant's Full Name:\_\_\_\_\_Date:\_\_\_\_\_

Home Address:\_\_\_\_\_

Street:\_\_\_\_\_

Town/City:\_\_\_\_\_State\_\_\_\_\_Zip Code\_\_\_\_\_

Home Phone Number:\_\_\_\_\_Business Phone Number:\_\_\_\_\_

Business Name:\_\_\_\_\_

Business Address:\_\_\_\_\_

Street

Town/City

State

Zip Code

Emergency Response Person:\_\_\_\_\_Telephone:\_\_\_\_\_

All residential addresses of applicant for the past five (5) years:

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D.O.B.:\_\_\_\_\_Sex:\_\_\_\_\_Height:\_\_\_\_\_Weight:\_\_\_\_\_Hair color:\_\_\_\_\_Eye Color:\_\_\_\_\_

Proof of age (copy of birth certificate or driver's license) submitted: Yes\_\_\_\_\_No\_\_\_\_\_

Two (2) front faced portrait photographs (2"x 2") within six (6) months submitted: Yes\_\_\_\_\_No\_\_\_\_\_

Social Security Number:\_\_\_\_\_

Proof of medical examination within thirty (30) days submitted: Yes\_\_\_\_\_No\_\_\_\_\_

Type of Massage to be practiced:\_\_\_\_\_

What education, training and experience have you had to qualify you to practice Massage?

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Diploma and transcript received: Yes\_\_\_\_\_No\_\_\_\_\_

Former occupations or Massage occupations of applicant for past three (3) years:

**Occupation**

**Name of Business and Address**

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At what place or places do you wish to be licensed to practice Massage?

**Business Name**

**Address**

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Have you had a license or permit to practice Massage suspended or revoked by any agency or board, city, county or state? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, explain:

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List all criminal convictions, forfeiture of bond, or plea of nolo contendere, excluding traffic, misdemeanor or infraction violations:

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I authorize and release the Board of Health to seek information or references necessary to verify the information contained in this application:

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

I certify under penalty of perjury that all information contained in this application is true and correct. Any misstatements in this application are grounds for refusing to issue or for revocation of any license issued.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

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BOARD OF HEALTH  
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**APPLICATION FOR MASSAGE ESTABLISHMENT OR OFF-PREMISES MASSAGE BUSINESS LICENSE**

License filing fee submitted: Yes\_\_\_\_\_ No\_\_\_\_\_

\$250 if one Massage Practitioner\_\_\_\_\_ \$350 if two or more Massage Practitioners

Business Name:\_\_\_\_\_

Applicant's Full Name:\_\_\_\_\_ Date:\_\_\_\_\_

Home Address:\_\_\_\_\_

No. Street

Town/City

State

Zip Code

Home Phone Number:\_\_\_\_\_ Business Phone Number:\_\_\_\_\_

Business Address:\_\_\_\_\_

No. Street

Town/City

State

Zip Code

Emergency Response Person:\_\_\_\_\_ Telephone:\_\_\_\_\_

All residential addresses of applicant for the past five (5) years:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

D.O.B.:\_\_\_\_\_ Sex:\_\_\_\_\_ Height:\_\_\_\_\_ Weight:\_\_\_\_\_ Hair color:\_\_\_\_\_ Eye Color:\_\_\_\_\_

Proof of age (copy of birth certificate or driver's license) submitted: Yes\_\_\_\_\_ No\_\_\_\_\_

Two (2) front faced portrait photographs (2"x 2") within six (6) months submitted: Yes\_\_\_\_\_ No\_\_\_\_\_

Social Security Number:\_\_\_\_\_

State of Incorporation:\_\_\_\_\_

Proof of authority to do business in Mass. (tax #) submitted: Yes\_\_\_\_\_ No\_\_\_\_\_

Federal Identification Number:\_\_\_\_\_

Articles of corporation or partnership submitted: Yes \_\_\_\_\_ No\_\_\_\_\_

If a corporation or partnership, please give name, title, and home address of officers, partnerships, stockholders with 10% or more of the stock. Supplemental Information pages must be submitted for each individual.

| Name | Title | Home Address | Home Telephone |
|------|-------|--------------|----------------|
|------|-------|--------------|----------------|

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Type of Massage to be practiced:\_\_\_\_\_

Number of full or part time Massage Practitioners:\_\_\_\_\_

Former occupations or Massage occupations of applicant for past three (3) years:

| Occupation | Name of Business and Address |
|------------|------------------------------|
|------------|------------------------------|

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Have you had a license or permit to practice Massage or conduct a Massage Establishment or Off-Premises Massage Business suspended or revoked by any agency or board, city, county, or state?

Yes\_\_\_\_\_No\_\_\_\_\_

If yes, explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List all criminal convictions, forfeiture of bond, or plea of nolo contendere, excluding traffic, misdemeanor or infraction violations:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I authorize and release the Board of Health to seek information or references necessary to verify the information contained in this application:

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

I certify under penalty of perjury that all information contained in this application is true and correct. Any misstatements in this application are grounds for refusing to issue or for revocation of any license issued.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

## SUPPLEMENTAL INFORMATION

Massage Establishment and Off-Premises Massage Business applicants must attach Supplemental Information pages for each partner or limited partner of applicant, if a partnership applicant, and each officer and director, if a corporate applicant, and any stockholder of a corporate applicant holding more than 10% of the stock of the corporate applicant with the following information:

Business Name: \_\_\_\_\_

Additional Individual's Full Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

No.

Street

Town/City

State

Zip Code

Home Phone Number: \_\_\_\_\_ Business Phone Number: \_\_\_\_\_

Business Name: \_\_\_\_\_

Business Address: \_\_\_\_\_

No.

Street

Town/City

State

Zip Code

All residential addresses of individual for the past five (5) years:

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D.O.B.: \_\_\_\_\_ Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Hair color: \_\_\_\_\_ Eye Color: \_\_\_\_\_

Proof of age (copy of birth certificate or driver's license) submitted: Yes \_\_\_\_\_ No \_\_\_\_\_

Two (2) front faced portrait photographs (2"x 2") within six (6) months submitted: Yes \_\_\_\_\_ No \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Former occupations or Massage occupations of individual for past three (3) years:

**Occupation**

**Name of Business and Address**

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Have you had a license or permit to practice Massage or conduct a Massage Establishment or Off-Premises Massage Business suspended or revoked by any agency or board, city, county or state?

Yes\_\_\_\_\_No\_\_\_\_\_

If yes, explain:

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List all criminal convictions, forfeiture of bond, or plea of nolo contendere, excluding traffic, misdemeanor or infraction violations:

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I authorize and release the Board of Health to seek information or references necessary to verify the information contained in this application:

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

I certify under penalty of perjury that all information contained in this application is true and correct. Any misstatements in this application are grounds for refusing to issue or for revocation of any license issued.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date